EDITORIAL

Integrated Care: Tools, Maps, and Leadership

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There is also a sense of unbalancing that must take place in order to push … into a new and larger set of circumstances.

—David Whyte, *The Three Marriages*

Those interested in comprehensive primary care will like this special issue of *JABFM*. This is perhaps the most advanced report to date about how integrated practices look and work, and what it takes to create and operate them. The practices reported here were selected with diversity in mind: in settings, system features, and the interventions themselves. Thus, there is something here for most practices. Moreover, these articles were written to illuminate the phenomenon of practice transformation from the perspective of clinicians, clinic staff, practice directors, educators, health information planners, architects, and system executives, all whom can find useful, actionable information within these pages. This editorial will look at a few of the issues these leaders face as they support and promote the change to comprehensive integrated primary care.

Successful integration is really hard. It takes longer than it seems like it should; it disturbs a clinic in unanticipated ways; it challenges cherished assumptions; and it does not show health benefits at first, even when the work is going well. At first, clinics fall short of reaching their intended populations.[1] It is inspiring to see how hard clinicians and staff will work and how much they will sacrifice to give their patients high-quality, integrated, whole-person care, but willingness alone is insufficient. In the absence of certain preconditions, it is nearly impossible for a clinical team to work together in an effective, integrated fashion. Electronic health records as they currently exist do not facilitate team-based care.[2] Physical space considerations really matter.[3] Staffing ratios and the way clinicians are scheduled determines whether integrated care is even possible.[4] The costs are usually not prohibitive (although sometimes they are), the ranges are wide, slow start-ups seem to be more expensive,[5] and system support is generally necessary.[6] Working together looks different from how we have heretofore conceived and modeled it. Although these practices were not observed repeatedly over time, it would seem that successful teams may begin with more collaboration, then as they mature and gain familiarity with each other's strengths and styles, they devolve back to a more efficient version of consultation and coordination—to less collaborative modes. So it may be that there is not a hierarchy of less to more desirable levels of collaborative care; rather, the most successful teams use a range of collaborative styles.[7]

Comprehensive integrated care can lead to better (ie, higher quality, more rewarding, less expensive) care, and healthier patients,[8] but the preconditions that produce this kind of care do not arise spontaneously. It takes leadership, and leadership of a particular kind. The creation of integrated, comprehensive primary care is not a technical proposition. Clinicians are not line workers who produce bits of health care, and clinics are not factories where health care is made. The special insights and evidence presented here are not useful

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Table 1 Complex Adaptive Leadership

Type of Leadership	Cardinal Features	Examples
Administrative	Build vision	"We will do whatever it takes to give our patients the best care possible"
	Acquire resources	Advocate for change in payment mechanisms
	Lead strategic planning	Hire sufficient staff for team-based care
	Manage crises	
Adaptive	Creativity	Adjust schedules of behavioral health clinicians
	Flexibility	Deploy care manager for home visits
	Solve problems	Develop new roles for appointment clerks
	Take risks	
Enabling	Catalyze adaptive solutions	Open evening clinics
	Deploy resources	Add home visits to clinics
	Protect flexibility	Migrate electronic health records to cell phones
	Provide structure	Set appropriate benchmarks
	Connect administrative and adaptive	

as prescriptions or specifications that, if followed, guarantee success. Health is personal, and the creation of a personal health plan requires the use of particular knowledge in particular ways. Likewise, the operation of a primary care clinic that renders personal, comprehensive, integrated health care occurs as a complex, emergent process. Clinics are complex, adaptive systems, and successful leadership must be understood in the context of such complex adaptive systems—not simply as a top-down, bureaucratic proposition, such as might work for a problem of physical production, but one that also enables the "bottom-up" flexibility, adaptability, learning, and continuous innovation that must be exercised in a successful complex adaptive system. We see evidence of both phenomena at play here, particularly in the most successful integrated clinics.

Complexity Leadership Theory can help us understand how these contrasting principles can work together.[9] Complexity Leadership Theory is a framework that accommodates control and coordination structures while at the same time accounting for the learning, creative, and adaptive capacity of complex adaptive systems. It recognizes 3 levels of leadership: administrative, adaptive, and enabling, as summarized in Table 1.

Administrative leadership is a top-down function that operates at an organizational level. Leaders in this role typically build vision, acquire resources, lead strategic planning, and manage crises. Administrative leaders can make decisions for the organization but must be ever mindful to keep their authority from interfering with bottom-up, adaptive problem solving. For example, the chief executive officer of one of the successful study clinic systems described his most important job as to "protect the vision and find talent, then stay out of their way."[10] In this case the vision that needed protection was that this system would "do whatever was necessary to give patients the best care possible—whatever it takes." Every member of this organization can and did recite this vision frequently. If this turns out to mean, as it did here, that it will require extensive onboarding of new staff to produce proper team-based care, administrative leaders have the authority to permit this, despite its unanticipated cost. This kind of administrative leadership might also be known as leadership from the symbolic frame,[11] or inspiring a shared vision.[12]

Adaptive leadership, in contrast, is not so much a leader in a particular role as it is a function: an emergent, interactive process among individuals that leads to the most critical adaptive changes in the organization. For example, several successfully integrated clinics continuously adjust the availability of the behavioral clinicians to maximize their availability to medical providers while minimizing "down" time; this is done by opening, closing, and moving scheduled slots as an ongoing process, a running conversation between the primary clinicians, care managers, behavioral clinicians, and scheduling staff, and is not managed by administrative leadership. Successful integration depends on the free exercise of adaptive leadership to deal with

the continuous stream of problems that arise in the course of normal primary care.

Enabling leadership works the territory between the administrative and the adaptive levels, and catalyzes adaptive solutions by a process of reciprocal protection and engagement called entanglement.[13] Enabling leaders will use authority or will access resources needed for adaptive problem solving, will keep administrative leadership apprised of new adaptive solutions (for dissemination), and will "prevent administrative leaders from stifling or suppressing beneficial interactive dynamics."[9] For example, physical workspace in successfully integrated settings facilitates access of team clinicians to one another; enabling leaders who recognize the need for propinquity have advocated to administrative leadership for redesign of clinic space to accommodate team-based communication. Another example: enabling leaders have organized and made time available for team meetings to discuss particularly complex patients or to discuss the daily schedules before the start of each day.

Efforts to integrate care founder due to lack of commitment and support by senior system leadership. This dataset contains examples of collaborative efforts that were hindered or halted by inadequate commitment and leadership from above. This can take the form of insufficient material support, indifference (or hostility) to collaboration and integration, rewards and incentives at odds with the collaborative process, or the promotion of a culture in which team-based care, creative problem solving, or quality improvement is discouraged ("just do your job and do not ask questions."). It can also manifest as insufficient orientation, training, and onboarding of new staff. Senior leaders do not necessarily need to be involved in individual quality improvement cycles or solving local workflow problems but their appreciation and support of such efforts is essential. An inspiring, galvanizing vision of coherent, comprehensive care from the highest levels can go a long way toward mobilizing the staff of a practice or members of an organization toward collaborative, team-based care.

The notion of a culture of collaboration is especially important here, and plays at all levels of leadership—administrative leaders must promote it, and adaptive leaders must operate fluently within it. Such a culture contains values that can be articulated by everyone in the practice. To quote the medical director at 1 of the exemplar practices:

> This is a practice that values the unique contributions of team members. We take the time to learn how we each work, what we are uniquely good for, and how we fit together. We take the time to communicate with each other about the care we provide, and that does take time. We take the time to get better at what we do, not to just do it. This is a practice that values flexibility and encourages trying new things to solve new problems, which always arise. We are always trying new ways to do things because we always have a long way to go. Mistakes are good if you just learn from them and keep moving. Usually the best answers come from the people doing the work on the ground, and not from the top. We value data. Tell us how we are actually doing so we can use it to get better.

There are several leadership issues tied up in this notion of the creation of a permissive culture. One is the creation of functional teams.[14,15] Practices that hew too rigidly to top-down, command-and-control leadership styles have difficulty meeting the demands of team-based care. Practices that recognize and reward leadership and initiative from even the lowest ranks of the organization seem to be more successful at providing comprehensive, integrated care. There is a way to flatten the hierarchy and loosen the 2-way communication that fosters creative problem solving and invests all stakeholders in the process.[5]

Before leaving this subject, we should mention a final, important issue: training the workforce. Almost without exception, integrated or integrating clinics had difficulty finding and hiring well-trained clinicians. Team clinicianship is not a skill either behavioral or primary care clinicians generally acquire in training. Integrated practices with sufficient resources and experience can train and extensively onboard their new hires until they are competent, and in fact do so, but this is expensive. It requires permissive senior leadership, experienced supervisors, a written training and policy manual, and sufficient breathing room in the

schedule to accommodate trainees. Novice and small practices generally do not have the resources or experience to accomplish this onboarding, and are thereby disadvantaged. This is an area where programs that train health care professionals and paraprofessionals desperately need to rise to the challenge and fill this gap.

As useful as this set of reports is for the field, we still have a lot to learn. This is a small sample of practices, and, diversity notwithstanding, cannot represent all the practices, problems, and solutions at play in the field today—we need to expand these findings with a broader sample of practices. Findings such as the collaborative, coordinated, and consultative modes of working together, as described by Cohen et al,[7] themselves suggest further questions, and need more detailed study—under different clinical or operational conditions, with different team members, over different time spans, and so on. The notion of leadership is incredibly important, and the skillful application of complex adaptive leadership to integrated care is just beginning. We have a great deal to learn about how our training pipelines can more effectively respond to the need for better-prepared, team-based clinicians.

Even though this is difficult work; even though it takes longer and is harder than anticipated; even though there are problems and complications at every turn; even though practices have to unbalance and disturb themselves to move ahead with collaborative care; even though all these things are true, this is a fundamentally inspiring story of clinics, clinicians, and staff who recognize these difficulties and prevail in the face of them. Almost without exception these practices made headway: they improved the quality of care they rendered, they learned to work together, and they overcame difficulties to do something better for their patients. And without exception, none wanted to go back to their old ways. Integrated, comprehensive care is here to stay, and it behooves us to learn its intricacies so that we may practice it more expertly.

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